AMENDED IN SENATE JUNE 14, 1999

CALIFORNIA LEGISLATURE—1999–2000 REGULAR SESSION

ASSEMBLY BILL No. 217

Introduced by Assembly Member Wildman

January 25, 1999

An act to ~~add Section 14105.436~~ *amend Section 1374.16 of, and to add Section 1365.6 to, the Health and Safety Code, and to add Section 14132.51* to the Welfare and Institutions Code, relating to human services.

LEGISLATIVE COUNSEL'S DIGEST

AB 217, as amended, Wildman. *Health care coverage:* Medi-Cal.

Existing law provides for the licensure and regulation of health care service plans, administered by the Department of Corporations. A violation of these provisions is subject to criminal sanction.

Existing law requires every health care service plan, except a specialized health care service plan, to establish and implement a procedure by which an enrollee with a condition or disease that requires specialized medical care over a prolonged period of time and is life-threatening, degenerative, or disabling may receive a referral to a specialist or specialty care center that has expertise in treating the condition or disease for the purpose of having the specialist coordinate the enrollee's health care.

This bill would require that the phrase "a condition or disease that requires specialized medical care over a long

period of time and is life-threatening, degenerative, or disabling" be interpreted broadly so as to maximize patient access to practitioners with demonstrated expertise in treating a particular condition or disease involving a complicated treatment regimen that requires ongoing monitoring of patient adherence.

This bill also would require a health care service plan to inform all enrollees as to what steps, if any, the plan has taken to provide referral to physician practices that have substantial experience in the treatment of human immunodeficiency virus (HIV).

Since this bill would change the definition of a crime, it would constitute a state-mandated local program.

Existing law provides for the Medi-Cal program, administered by the State Department of Health Services, under which qualified low-income persons are provided with health care services. One of the methods by which services are procured under the Medi-Cal program is through the use of managed care plans.

This bill would require a managed care plan to inform Medi-Cal recipients enrolled in the plan as to what steps, if any, the plan has taken to provide referral to physician practices that have substantial experience in the treatment of HIV.

The bill would require, with respect to Medi-Cal managed care plans, the department to develop risk-adjusted capitated rates for this treatment, in accordance with specified requirements.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

~~Under existing law, drugs that are approved by the federal Food and Drug Administration for use in the treatment of acquired immune deficiency syndrome (AIDS) or an AIDS-related condition are deemed to be approved for addition to the Medi-Cal list of contract drugs, and certain~~

~~other drugs are a Medi-Cal benefit subject to utilization controls.~~

~~This bill would provide that specified drugs or agents that are approved by the federal Food and Drug Administration for use in the treatment of AIDS or the human immunodeficiency syndrome (HIV) shall be added to the drug formularies used by defined Medi-Cal managed care plans and by primary care providers under specified case management contracts. This bill would require the State Department of Health Services either to reimburse the plans or contractors for these costs or recalculate capitation payments to include these costs under certain conditions.~~

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: ~~no~~ *yes*.

The people of the State of California do enact as follows:

~~SECTION 1. Section 14105.436 is added to the~~

SECTION 1. Section 1365.6 is added to the Health and Safety Code, to read:

1365.6. A health care service plan shall inform all enrollees as to what steps, if any, the plan has taken to provide referral to physician practices that have substantial experience in the treatment of HIV.

SEC. 2. Section 1374.16 of the Health and Safety Code is amended to read:

1374.16. (a) Every health care service plan, except a specialized health care service plan, shall establish and implement a procedure by which an enrollee may receive a standing referral to a specialist. The procedure shall provide for a standing referral to a specialist if the primary care physician determines in consultation with the specialist, if any, and the plan medical director or his or her designee, that an enrollee needs continuing care from a specialist. The referral shall be made pursuant to a treatment plan approved by the health care service plan in consultation with the primary care physician, the specialist, and the enrollee, if a treatment plan is deemed necessary to describe the course of the care. A treatment plan may be deemed to be not necessary provided that a

current standing referral to a specialist is approved by the plan or its contracting provider, medical group, or independent practice association. The treatment plan may limit the number of visits to the specialist, limit the period of time that the visits are authorized, or require that the specialist provide the primary care physician with regular reports on the health care provided to the enrollee.

(b) Every health care service plan, except a specialized health care service plan, shall establish and implement a procedure by which an enrollee with a condition or disease that requires specialized medical care over a prolonged period of time and is life-threatening, degenerative, or disabling may receive a referral to a specialist or specialty care center that has expertise in treating the condition or disease for the purpose of having the specialist coordinate the enrollee's health care. The referral shall be made if the primary care physician, in consultation with the specialist or specialty care center if any, and the plan medical director or his or her designee determines that this specialized medical care is medically necessary for the enrollee. The referral shall be made pursuant to a treatment plan approved by the health care service plan in consultation with the primary care physician, specialist or specialty care center, and enrollee, if a treatment plan is deemed necessary to describe the course of care. A treatment plan may be deemed to be not necessary provided that the appropriate referral to a specialist or specialty care center is approved by the plan or its contracting provider, medical group, or independent practice association. After the referral is made, the specialist shall be authorized to provide health care services that are within the specialist's area of expertise and training to the enrollee in the same manner as the enrollee's primary care physician, subject to the terms of the treatment plan.

(c) The determinations described in subdivisions (a) and (b) shall be made within three business days of the date the request for the determination is made by the enrollee or the enrollee's primary care physician and all

appropriate medical records and other items of information necessary to make the determination are provided. Once a determination is made, the referral shall be made within four business days of the date the proposed treatment plan, if any, is submitted to the plan medical director or his or her designee.

(d) Subdivisions (a) and (b) do not require a health care service plan to refer to a specialist who, or to a specialty care center that, is not employed by or under contract with the health care service plan to provide health care services to its enrollees, unless there is no specialist within the plan network that is appropriate to provide treatment to the enrollee, as determined by the primary care physician in consultation with the plan medical director as documented in the treatment plan developed pursuant to subdivision (a) or (b).

(e) For the purposes of this section, ''specialty care center'' means a center that is accredited or designated by an agency of the state or federal government or by a voluntary national health organization as having special expertise in treating the life-threatening disease or condition or degenerative and disabling disease or condition for which it is accredited or designated.

(f) As used in this section, a ''standing referral'' means a referral by a primary care physician to a specialist for more than one visit to the specialist, as indicated in the treatment plan, if any, without the primary care physician having to provide a specific referral for each visit.

(g) As used in this section, "a condition or disease that requires specialized medical care over a long period of time and is life-threatening, degenerative, or disabling" shall be interpreted broadly so as to maximize patient access to practitioners with demonstrated expertise in treating a particular condition or disease involving a complicated treatment regimen that requires ongoing monitoring of patient adherence.

SEC. 3. Section 14132.51 is added to the Welfare and Institutions Code, to read:

14132.51. (a) A managed care plan shall inform all Medi-Cal recipients enrolled in the plans as to what steps, if any, the plan has taken to provide referral to physician practices that have substantial experience in the treatment of HIV.

(b) (1) The department shall establish risk-adjusted capitated rates, to be applicable to managed care plans and primary care case management programs, for the treatment of Medi-Cal recipients infected with HIV.

(2) The rates established pursuant to this subdivision shall be consistent with efficiency, economy, quality of care, and access to care.

(3) Rates under this subdivision shall be established through the use of objective determinations of the total cost of providing medical care to persons infected with HIV that meet United States Department of Health and Human Services guidelines. Rates shall not be set through sole reliance on historical fee-for-service claims. In developing rates, the department shall include all relevant expenditures associated with providing medical care to persons infected with HIV.

(4) Rates developed pursuant to this subdivision shall be sufficient to enlist participation of HIV-specialty providers in geographic areas in which the state has initiated Medi-Cal managed care programs.

(5) For purposes of this section, capitation rates shall not exceed 95 percent of anticipated fee-for-service expenditures per patient per month.

(6) As part of the ratesetting process, the department shall develop a mechanism for the independent review, prior to their implementation, of the rates developed under this subdivision, in order to ensure all of the following:

(A) Consistency with efficiency, cost-effectiveness, quality of care, and access to care.

(B) The likelihood that, as a result of the proposed rates, a managed care plan will avoid developing a quality HIV program for fear of adverse selection.

(C) The likelihood that, as a result of proposed rates, a managed care plan will have a financial disincentive to

determine which of its members are infected with HIV and to provide treatment and medications for those individuals.

(7) For purposes of this section, all confidentiality protections applicable to the State AIDS Drug Assistance Program shall apply with regard to any individual who participates in a capitated Medi-Cal plan and would qualify for an HIV risk-adjusted rate. This section shall not require the reporting of an individual's HIV status without his or her consent.

SEC. 4. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

~~Welfare and Institutions Code, to read:~~

~~14105.436. (a) Any of the drugs or agents set forth in this section that are approved by the federal Food and Drug Administration for the treatment of human immunodeficiency virus (HIV) or acquired immune deficiency syndrome (AIDS) shall be added to the drug formularies used by managed care plans under this chapter and Chapter 8 (commencing with Section 14200), as described in subdivision (a) of Section 14093.05, and by primary care case management contracts executed pursuant to Section 14088.85, only for the purpose of treating HIV or AIDS.~~

~~(b) The following drugs and agents shall be added to the formularies pursuant to subdivision (a):~~

~~(1) Any vaccine to protect against human immunodeficiency virus (HIV) infection.~~

~~(2) Any antiviral agent, immune modulator, or other agent to be administered to persons who have been infected with human immunodeficiency virus to counteract the effects of that infection.~~

~~(c) For all drugs, vaccines, and antiviral agents referred to in this section, including tests required to administer those drugs, vaccines, and antiviral agents, the department shall do either of the following if the cost of these drugs or modalities have not been included in the capitation rates of the plans referenced in this section:~~

~~(1) Reimburse the plans or contractors on a fee-for-service basis for the cost of these drugs or modalities.~~

~~(2) Recalculate the capitation payments to the plans or contractors to include all relevant costs associated with the drugs, vaccines, agents, and tests. However, for all drugs, vaccines, and tests rendered prior to the implementation of any new capitation rate, the department shall reimburse the plans on a fee-for-service basis.~~

~~(d) Under no circumstances shall this section be interpreted to require coverage by a managed care plan of a drug, vaccine, or other agent referred to in this section that is not required to be on the Medi-Cal list of contract drugs pursuant to Section 14105.43.~~

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